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MEDICAID MEMO

Last Updated: 03/09/2022

Higher Payments for Medicaid Primary Care Services — Effective January 1, 2013 thru December 31, 2014 — Second Memo

As part of the Affordable Care Act, Medicaid agencies and Medicaid managed care plans are required to pay Medicare rates for Medicaid primary care services furnished by eligible physicians in calendar years 2013 and 2014. This requirement does not apply to reimbursement for services furnished to FAMIS members.

DMAS published a Medicaid Memo on December 28, 2012 discussing the requirements in the final rule published by the Centers for Medicare and Medicaid Services (CMS) in the November 6, 2012 Federal Register. The initial memo focused on determining eligible physicians through a process of self-attestation. Physicians who may be eligible for higher payments should review the earlier memo to determine the steps necessary to become eligible for the higher payments. Physicians who attest by March 31, 2013 will receive higher payment for eligible services furnished on or after January 1, 2013. Physicians who attest after March 31, 2013 will only receive the higher payment for eligible services from the beginning of the month of attestation. We have included additional information in this memo about certain aspects of attestation that DMAS did not know at the time of the December memo.

DMAS also announced in the December memo that it intended to make the higher payments using quarterly supplemental payments but had not yet determined all the details. The focus of this memo is on the details of the supplemental payments for FFS payments.

Providers can find all available information about the Medicaid primary care rate increase on the DMAS provider web portal at www.virginiamedicaid.dmas.virginia.gov. There are links on the left hand side of the welcome page to all Medicaid Memos, Frequently Asked Questions, the Attestation Form, a list of attesting physicians and information for managed care providers. Providers can access this information without registering for access to provider-specific information on the portal.

PROVIDER ATTESTATION

States must make increased payments for services furnished by a physician, or under the personal supervision of a physician with a specialty designation of family medicine, general internal medicine or pediatric medicine or a related subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA).

Eligible physicians must attest to a specialty designation of family medicine, general internal medicine and pediatrics or subspecialty and one of the following criteria below in order to receive the higher reimbursement rates for E&M services:

1. That they are a board certified physician with a specialty designation of family medicine, general internal medicine or pediatric medicine or a related subspecialty recognized by the ABMS, ABPS or AOA and/or

2. That they have furnished evaluation and management services and vaccine administration services that equal at least 60% of the Medicaid codes billed during the most recently completed calendar year or, for newly eligible physicians, the prior month.

The CMS final rule also indicates that primary care services furnished by nurse practitioners or physician assistants are eligible for higher payment, but only if furnished "under the personal supervision of an eligible physician." Nurse practitioners and physician assistants are not eligible to attest. In order to insure that services are furnished under the personal supervision of an eligible physician, DMAS will only pay the higher rate when those services are billed under the NPI of an eligible physician. Primary care services billed through a Health Department Clinic are not eligible for the higher payment, but health department clinic physicians may enroll separately as physicians, complete the attestation and bill for primary care services directly.

FEE-FOR-SERVICE PAYMENT PROCESS

Payment Schedule

Servicing providers that have attested by March 31, 2013 will be eligible for additional payments based on qualifying claims with service dates on or after January 1, 2013. Servicing providers that attest after March 31, 2013 will be eligible for additional payments based on claims with service dates on or after the 1st of the month in which they attest. Quarterly payments will be based on qualifying claims with Friday remittance dates within the quarter. Claims with remittance dates after the end of the quarter will be processed the following quarter. For example, a provider who has attested February 15, 2013 and has a qualifying claim with a service date of January 11 but has a delay in submitting or processing the claim so that the remittance date is April 5, 2013 will have the additional payment from that claim included in their July additional payments. Providers can view their attestation date on the provider web portal.

DMAS has submitted a State Plan Amendment for CMS approval. DMAS will not make payments until the State Plan Amendment is approved, and will notify providers through RA notices, blast emails and a notice on the Provider Web portal. Assuming the State Plan Amendment has been approved by CMS, DMAS will use the following schedule in April. DMAS will calculate the additional payment for the first quarter in early April for payment on the April 19 remittance. The financial transaction information will be available as usual on the remittance advice (RA) available on April 15, but will not include detail information at the claim level. DMAS will produce a separate claim-level detailed report for the billing provider, which may be necessary to allocate payments to the correct servicing provider, and any other billing reconciliation tasks you may perform. DMAS will post the claim-level detailed report to the DMAS web portal at the same time the RA is available with the additional payment. DMAS will follow a similar schedule for each quarter. DMAS will post the payment and report schedule quarterly on the web portal.

DMAS will pay higher rates for primary care services for dates of service in CY 13 and CY14. However, claims can be submitted up to a year after the service date, and claims can be voided or adjusted for an additional year after that. Therefore, providers may receive additional payments through the end of CY16. There will be cases

when the voided claims for a particular provider will be more than their positive additional payments. In those cases, the additional payment will be a recoupment, processed in a similar manner.

Medicare Enhanced Rates

The eligible primary care procedure codes (generally E&M codes and vaccine administration codes associated with the Vaccine for Children program) and the enhanced Medicare rates used to calculate the additional payments are published on the web portal. DMAS also calculated a "Medicare" triage rate for Level III Emergency Department Visit (99283) that is determined to not be an emergency. The enhanced Medicare rates are higher than the current Medicare rates. DMAS will pay the same rate regardless of site of service. The enhanced Medicare rates have a rate for Northern Virginia and a rate for the rest of state based on the Medicaid zip code file available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html. Zip codes in the Medicare Virginia 01 location are in Northern Virginia and the Medicare Virginia 00 location are in the rest of the state. Higher payments will only be made for Medicaid claims. DMAS will not make additional payments for primary care services furnished to FAMIS members or from the Temporary Detention Orders Program.

Payment Calculation

The calculation of the additional payment for CMS 1500 claims submitted directly to Medicaid will be the difference between the enhanced Medicare rates and the total paid amount of the original or adjusted claim, including amounts paid by the member (copays) and amounts paid by third parties The total payment will be the lower of the enhanced Medicare rates or billed charges for E&M codes. CMS has not yet advised DMAS whether the same rule applies to vaccine administration.

Additional payments for Medicare crossovers will be calculated in a similar manner, even claims for which Medicaid initially made no payment. In some cases crossover claims are paid not based on rates but on owed yearly deductible amounts. There will be no additional payments on these claims that are not paid based on rates.

Payment Report

The claim level detailed report is designed to assist billing providers in allocating additional payments to the appropriate servicing provider as required by the legislation and to reconcile the additional payments to the original claim or adjustment if desired. All additional payments, calculated on a claim line by claim line basis including negative amounts for claim lines that record voided claims, will be summed by billing provider and put into one to four additional payments. Multiple payments are necessary for reporting to CMS.

The report will contain the following information for each billing provider in order to track the additional payment to a specific remittance advice:

- DMAS FCN (Financial Control Number)
- Financial Reason Code and Description
- Financial Transaction Payment Amount
- Remit Number and Remit Date associated with Financial Transaction

Detailed claim level information will then be sorted by servicing provider with the following information:

- Servicing provider NPI
- Member name
- Member Medicaid ID Number
- Patient account number (submitted on the claim by the billing provider)
- DMAS ICN (internal control number of claim)
- Remit Number and Date (that the claim was paid or adjusted)
- Original Payment
- Additional Payment

The report will be posted to the web portal in a format that can easily be opened by most Excel programs. Billing providers will need to be registered on the web portal for access to these reports. Many providers utilize and access Web RAs, Direct Data Entry and Provider Profile Maintenance services through the DMAS provider web portal today. If you are not already registered, please contact the Web Portal Helpdesk toll free at 1-866-352-0496 for help registering on the web portal and/or for assistance in downloading the report. DMAS strongly recommends that providers register for the web portal for this report and other information.

MANAGED CARE

Managed care plans are also required to make higher payments to eligible primary care providers for eligible primary care services. DMAS pays Managed Care Organizations (MCOs) a monthly capitation payment for each eligible member enrolled in the MCO. DMAS will calculate the required increase in capitation payment to MCOs actuarially determined to be sufficient to cover the cost of MCOs paying eligible physicians the enhanced Medicare rate for E&M and vaccine administration services. DMAS will not make the higher capitation

payments until the Centers for Medicare and Medicaid Services has approved the contracts and rates. The plans have indicated that they will begin to make higher payments only after receiving the higher capitation rates. DMAS anticipates that it will make higher capitation payments in May or June.

The Act requires that eligible physicians receive direct benefit of the payment increase for each of the primary care services specified in this rule. This requirement must be met regardless of whether a physician is part of a group, salaried, or receives a fee for service or capitated payment from the MCO. MCOs will provide assurances that the higher payment will actually be passed on for services furnished by the primary care physicians designated in statute. The structure of the MCO's provider network does not mitigate this responsibility.

Each MCO is responsible for determining how it will make higher payments to eligible providers. Some will use quarterly additional payments similar to DMAS while others will pay eligible claims at the higher rate. MCOs are responsible for contacting physicians in their networks about attestation and payments. Providers should contact each MCO for more information.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1- 800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KePRO's Provider Portal at http://dmas.kepro.com.